State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act

Section 1309:

RIte Care

December 2013
March 2014 (T)
June 2014
March 2016 (E)
July 2016

Rhode Island Executive Office of Health and Human Services

Access to Medicaid Coverage under the Affordable Care Act

Rules and Regulations Section 1309:

RITE CARE

TABLE OF CONTENTS

Introduction

These rules related to **Access to Medicaid Coverage Under the Affordable Care Act, Section 1309 of the Medicaid Code of Administrative Rules entitled, "RIte CARE"** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance), including Public Law 13-144; Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15); Rhode Island Executive Order 11-09; and the Code of Federal Regulations 42 CFR Parts 431, 435, 436 *et seq.*

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede all previous requirements related to Medicaid coverage provided under the federal Affordable Care Act as contained in Section 1309 of the Medicaid Code of Administrative Rules entitled, "RIte CARE" promulgated by the Executive Office of Health and Human Services and filed with the Secretary of State.

1309 RIte Care Program

1309.01 Overview

RIte Care was initially established as a statewide managed care demonstration project in 1994 under a Medicaid Title XIX Section 1115 waiver. The project's goal was, and continues to be, to use a managed care delivery system to increase access to primary and preventative care for certain individuals and families who otherwise might not be able to afford or obtain affordable coverage. Medicaid members participating in RIte Care are enrolled in a managed care organization (MCO), a type of health plan which uses a primary care provider to coordinate all medically necessary health care services through an organized delivery system. The Medicaid agency contracts with MCOs to provide these health services to members at a capitated rate or fixed cost per enrollee per month.

Individuals and families who have access to employer-sponsored health insurance plans are evaluated for participation in the RIte Share Premium Assistance Program in accordance with provisions contained in MCAR section 1312. Adults in these families are required to enroll any Medicaid-eligible family members in a RIte Share approved plan as a condition of retaining Medicaid eligibility.

1309.02 Scope and Purpose
REV: June 2014

Effective on January 1, 2014, Rhode Island is implementing a new eligibility system for individuals and families seeking affordable coverage funded in whole or in part by Medicaid, tax credits, and/or other public subsidies. The new system uses a single standard – modified adjusted gross income (MAGI) – to determine income eligibility for affordable coverage across populations. To facilitate the transition to the MAGI, the RI Medicaid agency has reconfigured these populations into four distinct Medicaid affordable care coverage (MACC) groups: families, pregnant women, children and adults without dependent children (See MCAR Section 1301.03). Eligible members of three of these four coverage groups – all but adults 19-64 otherwise ineligible for Medicaid – will be enrolled in a RIte Care health plan or, as applicable, RIte Share.

The purpose of this rule is to describe the RIte Care delivery system and the respective roles and responsibilities of the Medicaid agency and the individuals and families that are receiving affordable coverage through a RIte Care MCO.

1309.03 Program Management

Title XIX of the U.S. Social Security Act provides the legal authority for the RI Medicaid program. The RIte Care program operates under a waiver granted by the Secretary of Health and Human Services (HHS) pursuant to Section 1115 of the Social Security Act. The RIte Care Managed Care

Consumer Advisory Committee was established by Executive Order in February 1994. The Committee is available to RIte Care consumers to address suggestions, complaints, or related issues.

1309.04 Definitions

For the purposes of this rule, the following definitions apply:

"Communities of Care (CoC)" means the special delivery system that provides more intensive care management within a limited network to Medicaid members enrolled in either RIte Care or Rhody Health Partners who have Emergency Department utilization rates at or above the threshold for participation set by the Medicaid agency.

"Managed Care Organization (MCO)" means a health plan system that integrates an efficient financing mechanism with quality service delivery, provides a "medical home" to assure appropriate care and deter unnecessary services, and place emphasizes preventive and primary care.

"Medicaid Affordable Care Coverage (MACC) Group" means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014 as follows:

- Families and Parents/Caretakers with income up to 133% of the Federal Poverty Level (FPL) – Includes families and parents/caretakers who live with and are responsible for dependent children under the age of 18 or 19 if enrolled in school full-time. It also includes families eligible for time-limited transitional Medicaid.

- Pregnant women. Members of this coverage group can be of any age. The pregnant woman and each expected child are counted separately when constructing the household and determining family size. Eligibility extends for the duration of the pregnancy and two months post-partum. The coverage group includes all pregnant women with income up to 253% of the FPL, regardless of whether the legal basis of eligibility is Medicaid or CHIP, including pregnant women who are non-citizen residents of the State. The unborn child's citizenship and residence is the basis for eligibility.

- Children and Young Adults. Age is the defining characteristic of members of this MACC group. This coverage group includes: infants under age 1, children from age 1 to age 19 with income up to 261% of the FPL; and qualified and legally present non-citizen infants and children up to the age of 19, who have income up to 261% of the FPL.

- Adults 19-64. This is the new Medicaid State Plan expansion coverage group established in conjunction with implementation of the ACA. The group consists of citizens and qualified non-citizens with income up to 133% of the FPL who meet the age characteristic and are not

otherwise eligible for, or enrolled in, Medicaid under any other state plan or Section 1115 waiver coverage group. Adults found eligible for Social Security benefits are also eligible under this coverage group during the two (2) year waiting period.

"Medicaid Code of Administrative Rules (MCAR)" means the collection of administrative rules governing the Medicaid program in Rhode Island.

"Medically Needy" means a classification of persons eligible to receive Medicaid based upon similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014.

"Member or enrollee" means a Medicaid-eligible person receiving benefits through a RIte Care managed care organization.

"New Applicant" means an individual or family that was not enrolled in and receiving Medicaid coverage on the January 1, 2014, effective date this rule. The term does not apply to individual and families who were receiving coverage and where disenrolled for any reason; nor does it apply to parents with income between from 133% to 175% of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended).

"**Non-MAGI Coverage Group**" means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. Includes Medicaid for persons who are aged, blind or with disabilities and persons in need of long-term services and supports as well as individuals who qualify for Medicaid based on their eligibility for another publicly-funded program, including children in foster care and anyone receiving Supplemental Security Income (SSI) or participating in the Medicare Premium Assistance Program.

"Prudent Lay Person Standard" means the standard used to determine the need for an emergency room visit. An "emergency" is defined as a condition that a prudent lay person "who possesses an average knowledge of health and medicine" expects may result in: (1) placing a patient in serious jeopardy; (2) serious impairment of bodily function; or (3) serious dysfunction of any bodily organs.

"Rhody Health Partners" means the Medicaid managed care program that delivers affordable health coverage to eligible adults without dependent children, ages 19 to 64, under MCAR section 1311 and adults with disabilities eligible under section 0374.

"**RIte Care**" means the Medicaid managed care delivery system for eligible families, pregnant women, children up to age 19, and young adults older than age 19 (see section 1309 of the Medicaid Code of Administrative Rules).

“RIte Share” means the Medicaid premium assistance program for eligible individuals and families who have access to cost-effective commercial coverage.

"Urgent Medical Problem” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four hours could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

1309.05 Coverage Groups in RIte Care

The RIte Care population consists of members of: certain Medicaid affordable care coverage (MACC) groups; coverage groups whose eligibility is NOT based on the MAGI standard (non-MAGI) and several non-Medicaid coverage groups.

01. Medicaid Affordable Care Coverage (MACC) Groups -- RIte Care plans provides coverage for individuals and families in the following MACC groups:

(01) Families with income up to 110% of the FPL and parents and caretaker relatives with income between 110% and 133% of the FPL who have dependent children up to age 18 or, if attending school full-time, up to age 19.

(02) Pregnant women with family income up to 253% of the FPL, including non-citizen pregnant women.

(03) Children up to age 19 with family income up to 261% of the FPL, including qualified non-citizen children.

02. Non-MAGI Coverage Groups – RIte Care MCOs also provide health services to:

(01) Children up to age 18 or 19 if completing school who are in foster care and/or receiving adoption subsidy under the applicable provisions of Title IV-E of the federal Social Security Act (See MCAR sections 0342.70 through 0342.75).

(02) Children up to age 21 who are Medicaid eligible as result of receiving Supplementary Security Income (SSI). Individuals in the SSI eligible group under age twenty-one (21) who are enrolled in RIte Care managed care may continue enrollment in a RIte Care health plan when they turn twenty-one (21) years of age until such time as SSI eligibility is discontinued.

(03) Young adults aging out of foster care between the ages of 18 and 26. Young adults who were in participating in foster care, kinship, and guardianship programs authorized by the RI Department of Children, Youth and Families (DCYF) on the date they turned 18 are eligible, without regard to income, for continued Medicaid coverage until the age of 26 under the Foster Care Independence Act of 1999, as amended by the Affordable Care Act of 2010. Members of this population are only eligible in Rhode Island if they were residing in the State at the time they aged out of DCYF foster care. EPSDT services continue only up to age 21 for members of this non-MAGI coverage group.

03. Non-Medicaid funded Coverage Groups – The RIte Care coverage groups in this category are not eligible for federal Medicaid federal financial participation (matching funds).

- Pregnant women with income between 253% and 350% of the FPL. Women who qualify for coverage in this group receive the same MCO in-plan benefits as pregnant women eligible under Title XIX and Title XXI. This group is composed of women with income above 253% but not exceeding 350% of the FPL. Women in this category are not entitled to any fee-for-service coverage for medical services, including those rendered prior to enrollment in a health plan.

- Pregnant women with income exceeding 350% of the FPL. Uninsured or under-insured pregnant women with countable income above 350% of the FPL are allowed to purchase coverage directly from the MCO. The pregnant woman must pay a monthly premium directly to the health plan providing coverage. This premium includes the monthly negotiated capitation rate and the supplemental delivery payment. Eligibility is verified by the applicant furnishing the health plan with the EOHHS notice of denial due to excess income.

1309.06 Excluded Medicaid Coverage Groups
REV: July 2016

There are Medicaid-eligible children and families who receive coverage on a fee-for-service basis rather than through a RIte Care plan, as follows:

(01) Members of these coverage groups who are covered by employer-sponsored or other third party health insurance, may receive Medicaid on a fee-for-service basis, rather than through enrollment in a RIte Care health plan:
- IV-E foster children and children receiving adoption subsidy (Section 0342.70).
- SSI recipients under age twenty-one (21) (Section 0370.05).
- Children with disability - Katie Beckett Eligible. (Section 0370.20 and 0394.35). Children under age nineteen (19) who: are living at home; require a hospital, nursing

home or ICF-ID level of care; and would qualify for Medicaid if in a licensed health care institution.

- SSI recipients over age twenty-one (21).

(02) Medically needy populations. Flex-test cases (see MCAR section 0336) are included in the RIte Care program but receive services in the fee-for-service system. The income deeming methodology permitted by the waiver is applied to new medically needy flex-test applicants. With the exception of Katie Beckett children, long-term care coverage groups (Section 0394) do not receive services through a RIte Care managed care plan.

(03) Extended family planning group. Individuals in this RIte Care waiver group are entitled to a limited scope of services rather than comprehensive benefits. The group consists of women who meet the following conditions: income must be above the Medically Needy income limit; if pregnant, income must not exceed 253% of FPL; the women must be sixty (60) days postpartum or sixty (60) days post-loss of pregnancy and, as a result, subject to discontinuation of Medicaid eligibility. Coverage is available for up to twenty-four (24) months.

1309.07 Retroactive Coverage

Requests for retroactive eligibility are evaluated at the time of application, but must not delay a decision on prospective eligibility. Retroactive eligibility is not available to MACC groups enrolled in RIte Care. Foster and adoption subsidy children in Non-MAGI coverage groups are eligible for retroactive coverage if eligible for SSI. Retroactive coverage is also available to SSI-related eligible individuals and SSI-related medically needy flex-test cases. If eligibility exists, retroactive payment for services is on a fee-for-service basis.

1309.08 Co-Payment Requirements

State-funded pregnant women with income above 253% of the FPL and extended family planning participants who have income above 185% of the FPL are required to make point-of-service copayments as listed below. Copayments are per person/per episode and are payable to the health care provider at the time of service.
Co- Pays for State-funded Pregnant Women, Income 253%-350% FPL --

- $ 5.00 - Office visits for all ambulatory encounters except for prenatal and preventative visits
- $15.00 - Ambulatory surgical procedures
- $ 2.00 - Prescriptions
- $25.00 - Unauthorized non-emergency use of the emergency room
- $35.00 - Non-emergency use of emergency transportation

Copayments for Extended Family Planning, Regardless of Income Level –

- $ 2.00 - Health care provider visits
- $ 1.00 - Thirty (30) day supply of contraceptives
- $15.00 - Voluntary sterilization procedures

1309.09 Overview of RIte Care Services

Individual and families enrolled in RIte Care receive the full scope of services covered under the Medicaid State Plan and the State's Section 1115 waiver, unless otherwise indicated. Covered services may be provided through the managed care plan or through the fee-for-service delivery system if the service is "out-of-plan" – that is, not included in the managed care plan but covered under Medicaid. Fee-for-service benefits may be furnished either by the managed care provider or by any participating provider. Rules of prior authorization apply to any service required by the Medicaid agency. The extended family planning group is entitled only to family planning services.

Each RIte Care member selects a primary care physician (PCP) who performs the necessary medical care and coordinates referrals to specialty care. The primary care physician orders treatment determined to be medically necessary in accordance with MCO policies. Individuals in the Extended Family Planning (EFP) coverage group do not require a PCP.

01. Access to Benefits – Unless otherwise specified, members of all RIte Care coverage groups (MACC, Non-MAGI, and Non-Medicaid Funded) are entitled to a comprehensive benefit package that includes both in-plan and out-of-plan services. State-funded pregnant women are eligible for in-plan services only while pregnant and in the two month postpartum period. All other pregnant women are eligible for the comprehensive benefit package through delivery and for two months postpartum or post-loss of pregnancy. In-plan services are paid for on a capitated basis (fixed cost per enrollee per month). The State may, at its discretion, identify other services paid for on a fee-for-service basis rather than at a capitated rate.

02. Delivery of Benefits – The coverage provided through the RIte Care is categorized as follows:
    - In-Plan Capitated Benefits, including: RIte Care Comprehensive Benefit Package; Extended Family Planning Services; Special Services for Severely and Persistently Mentally Ill (SPMI)
    - In-Plan Fee-for-Service Benefits
    - Out-of-Plan Benefits
    - Early Periodic Screening, Diagnosis and Treatment (EPSDT) Out-of-Plan Services.

03. Medical necessity – The standard of "medical necessity" is used as the basis for determining whether access to Medicaid-covered services is required and appropriate. A "medically necessary service" means medical, surgical or other services required for the prevention,

diagnosis, cure, or treatment of a health-related condition including any such services that are necessary to prevent a detrimental change in either medical or mental health status. Medically necessary services must be provided in the most cost-efficient and appropriate setting and must not be provided solely for the convenience of the member or service provider.

04. Early Periodic Screening, Diagnosis and Treatment (EPSDT) -- The EPSDT provision in Title XIX mandates that the Medicaid agency must provide coverage for all follow-up diagnostic and treatment services deemed medically necessary to ameliorate or correct defects and physical and mental illnesses and conditions discovered through screening or at any other occasion, whether or not those services are covered by the State Medicaid Plan or the State's Medicaid Section 1115 waiver. This applies to members of the MACC group up to age nineteen (19), SSI-eligible children and young adults up to age twenty-one (21), including adults aging out of foster care up to age twenty-one (21). A young adult over age nineteen (19) who transitions from the MACC group for children and young adults to the MACC group for adults from age 19 to 64 also receives EPSDT services until age 21.

1309.10 RIte Care In-Plan Capitated Benefits

REV: July 2016

The following are the benefits which the health plan provides or arranges within the capitated (fixed cost per enrollee per month) benefit. In-Plan benefits subject to the capitated rate are organized as follows: the RIte Care comprehensive benefit package and the extended family planning benefit package. Adults who are found to be severely and persistently mentally ill have access to a modified comprehensive benefit package. All elements of the comprehensive benefit package are the responsibility of the health plan when beneficiaries in this group receive coverage through the RIte Care managed care delivery system.

01. RIte Care comprehensive benefit package --The following benefits are included in the capitated rate on an annual basis, based on medical necessity:

RIte Care Health Plans – In-Plan Comprehensive Benefit Package	
Service/Benefit	***Scope of Coverage***
Inpatient hospital care	Up to 365 days
Outpatient hospital services	Includes physical therapy, occupational therapy, and speech, hearing, and language services
Physician services	Includes surgical services including reconstructive surgery as medically necessary. Second surgical opinion to an in network or out-of-network physician, as ordered by a plan physician
Family planning services	Services include family planning counseling, (available to eligible men and women) extended family planning services, (see section 1309.14) with the exception of certain non-prescription family planning materials that are not Medicaid covered benefits, including: foam, condoms, and spermicidal jelly
Prescription medications	Covered in compliance with the Medicaid agency's generic drug policy (see section 1309.11.01.01)

RIte Care Health Plans – In-Plan Comprehensive Benefit Package	
Service/Benefit	***Scope of Coverage***
Non-prescription drugs	When prescribed by a health plan physician, limited to non-prescription drugs identified as covered by the Medicaid agency
Laboratory, radiology and diagnostic services	When ordered by a health plan physician
Behavioral health services	Includes drug screens, substance abuse services necessary, and sexual abuse counseling
Outpatient behavioral health	Includes day treatment and inpatient substance abuse services and partial hospitalization
Residential treatment	Residential substance abuse treatment for adolescents thirteen (13) to seventeen (17) years of age or residential treatment ordered by the Department of Children, Youth, and Families are out-of-plan benefits
Methadone maintenance and methadone detox	As ordered by an outpatient services health plan physician
EPSDT	Services provided to all children and young adults up to age 21. Includes tracking, follow-up and outreach to children for initial visits, preventive visits, follow-up vision, hearing, and dental visits. Includes interperiodic screens as medically indicated. Includes multidisciplinary evaluation and treatment for children with significant developmental disabilities or developmental delays. See section 1309.14 for out-of-plan benefits
Early Intervention services	Center-based health and education programs for children at risk for being developmentally delayed
Certified home health agency as ordered by a health plan, physician services (short-term acute)	As ordered by a health plan physician. Short-term acute includes all medically necessary home health services with the exception of home health care provided in lieu of care in a nursing facility
Post-stabilization care	As ordered by a physician in an urgent or emergency care setting
Emergency room services and transportation when provided outside of the State based on the prudent lay person standard	Services provided in accordance with the prudent layperson standard. See definition in section 1309.04. Must be provided in the United States
Nursing facility services	In an appropriately licensed nursing facility when ordered by a health plan physician
Private duty nursing licensed nurse midwives	As ordered by a health plan physician
Services of other health practitioners – includes practitioners, including any practitioners, certified and licensed by the State such as nurse practitioners, physician assistants, social workers, licensed dieticians, psychologists, and licensed nurse midwives	If referred by a health plan physician
School based health centers	If referred by primary care physician (PCP)
Podiatry services	As ordered by health plan physician
Optometry services	For adults 21 and older, benefit is limited to examinations that include refractions and eyeglass dispensing, once every two years, and any other medically necessary treatment visits for illness or injury to the eye. For children under 21 covered as medically necessary with no other limits
Durable medical equipment	As ordered by a health plan physician. Includes surgical appliances, prosthetic devices, orthotic devices, medical supplies, hearing aids, and molded shoes

RIte Care Health Plans – In-Plan Comprehensive Benefit Package	
Service/Benefit	***Scope of Coverage***
Hospice services	As ordered by a health plan physician
Nutrition services.	As referred to licensed dietitian by a health plan physician for certain medical conditions
Group education/programs,	On a self-referral basis including childbirth education classes, parenting classes, and smoking cessation programs
Non-emergency transportation	In accordance with section 1309.10.02
Interpreter services	For enrollees who speak a language other than English as their first language as described in section 1309.10.03
Organ transplant services	As described in Section 0300.20.05 and 0300.20.05.25, Organ Transplant Operations
Tracking, follow-up and outreach	In accordance with section 1309.10.04

Medicaid agency policy affects the access to and/or the scope and amount of several of these benefits as follows:

(01) Prescriptions: Generic Policy. For RIte Care enrolled members, prescription benefits must be for generic drugs. Exceptions for limited brand coverage for certain therapeutic classes may be granted if approved by the Medicaid agency, or the MCO acting in compliance with their contractual agreements with EOHHS, and in accordance with the criteria described below:

- Availability of suitable within-class generic substitutes or out-of-class alternatives.
- Drugs with a narrow therapeutic range that are regarded as the standard of care for treating specific conditions.
- Relative disruptions in care that may be brought on by changing treatment from one drug to another.
- Relative medical management concerns for drugs that can only be used to treat patients with specific co-morbidities.
- Relative clinical advantages and disadvantages of drugs within a therapeutic class.
- Cost differentials between brand and generic alternatives.
- Drugs that are required under federal and State regulations.
- Demonstrated medical necessity and lack of efficacy on a case by case basis.

(02) Non-emergency transportation policy. Responsibility for transportation services rests first with the member. If the member's condition, place of residence, or the location of medical provider does not permit the use of bus transportation, non-emergency transportation for the Medicaid enrollee may be arranged for by EOHHS or its agent for transportation to a Medicaid-covered service from a Medicaid-participating provider. Includes bus passes, Rhody Ten Ride passes, RIPTIKS, other RIPTA fare products and also includes RIPTA paratransit vans and taxi services, if authorized by EOHHS or its agent.

(03) Interpretation services policy. EOHHS will notify the health plan when it knows of members who do not speak English as a first language who have either selected or been

assigned to the plan. If the health plan has more than fifty (50) members who speak a single language, it must make available general written materials, such as its member handbook, in that language.

(04) Tracking, Follow-up, Outreach. These services are provided by the health plan in association with an initial visit with member's PCP; for preventive visits and prenatal visits; referrals that result from preventive visits; and for preventive dental visits. Outreach includes mail, phone, and home outreach, if necessary, for members who miss preventive and follow-up visits, and to resolve barriers to care such as language and transportation barriers.

02. Extended family planning services -- The extended family planning group benefit package includes:

- Gynecological Services. Limited to no more than four (4) office visits annually -- One (1) comprehensive gynecological annual exam and up to three (3) additional family planning method related office visits if indicated)

- Laboratory. Includes annual Pap smear; STD screening if indicated; anemia testing; dipstick urinalysis and urine culture if indicated; pregnancy testing.

- Procedures. Limited to the following office/clinic/outpatient procedures if indicated tubal ligation; treatment for genital warts; Norplant insertion and removal; IUD insertion and removal; incision and drainage of a Bartholin's gland cyst or abscess.

- For RIte Care enrolled members. Includes generic-first prescriptions and non-prescription family planning methods (Limited to twelve (12) 30-day supplies per year) when prescribed by a health plan physician.

- Contraceptives. Includes oral contraceptives, contraceptive patch, contraceptive vaginal, contraceptive implant, contraceptive IUD, contraceptive injection, cervical cap, diaphragm, and emergency contraceptive pills, when prescribed by a health care physician. Covered non-prescription methods include foam, condoms, spermicidal cream/jelly, and sponges.

- Referrals for other medically necessary services as appropriate/indicated, including: referral to State STD clinic for treatment if indicated.

- Referral to State confidential HIV testing and counseling sites, if indicated.

- Inpatient services are not a covered benefit, except as medically necessary follow-up treatment of a complication from provision of a covered procedure or service.

Categories of eligibility for this extending family planning benefit package are as follows:

(01) Women otherwise Medicaid ineligible. The package of services is available without the comprehensive benefit package. Women who have given birth and are not eligible for Medicaid under another coverage group, lose the full scope of covered services sixty (60) days postpartum or post-loss of pregnancy. Women in this category are eligible for RIte Care for a period of up to twenty-four (24) months for the full family planning benefit package. The benefit package includes interpreter services but does not include transportation benefits. Re-certification is required at twelve (12) months.

(02) Women who are otherwise eligible for Medicaid. Women enrolled in RIte Care are eligible for family planning services. Participation is voluntary. Members continue to be enrolled with the same health plan they selected or were assigned to for comprehensive health service delivery but for family planning services only for a twelve (12) month period. Upon re-certification at twelve (12) months, a participant may qualify for up to an additional twelve (12) months. Services are covered on an outpatient basis only. Non-prescription contraceptives are not covered for members in this category.

1309.11 In-plan Fee-For-Services Benefits

The health plan or its approved providers will bill the Medicaid agency for fee-for-service for Medicaid State Plan and Section 1115 waiver covered in-plan benefits that have not been included in the capitated rate.

1309.12 Out-of-Plan Benefits

REV: July 2016

Out-of-plan benefits are not included in the capitated rate and are not the responsibility of the health plan to provide or arrange. These services are provided by existing Medicaid-approved providers who are reimbursed directly by the Medicaid agency on a fee-for- service basis. Out-of-plan benefits are provided to all RIte Care enrollees with the following exceptions: Individuals eligible for Extended Family Planning only; State-funded pregnant and post-partum women with income above 253% of FPL; and anyone enrolled in the guaranteed enrollment period but otherwise ineligible for Medicaid (Section 0348.35.10). The covered benefits are as follows:

01. Court-ordered services to out-of-network providers;

02. Residential substance abuse treatment services for adolescents (thirteen (13) to seventeen (17) years old);

03. Routine dental services (emergency dental services are in-plan);

04. Family planning services. RIte Care recipients may seek family planning services either in-plan or from an out-of-plan provider. When members seek these services in-plan, the plan must provide them as part of its capitated benefit package and may not bill the State fee-for-service. However, members are permitted to self-refer. For those individuals who elect to go out of network, the plan will reimburse the provider on a fee-for-service basis;

05. Non-medical case management for Head Start children;

06. Home visits for assessment and follow-up of Level I screenings (Family Outreach Program);

07. School-based health services as defined in the child's Individual Education Plan (IEP) for children with special health needs or developmental delays;

08. Lead program home assessment/intervention and nonmedical case management provided by the Department of Health for children with lead poisoning;

09. Home-based treatment services for children;

10. CEDARR Services;

11. Seriously and Persistently Mentally Ill Adults & Seriously Emotionally Disturbed Children are provided Juvenile Drug Court Case Management Services (provided by Case Care Coordinators (CCP)).

12. Home stabilization services are available for beneficiaries eligible under MCAR 1301 who are homeless or at-risk for homelessness or transitioning from the community from institutional settings and *do not qualify for such services through any other federally-funded program administered by the state*. Home stabilization services encompass a broad range of time limited tenancy support services assisting with home find, tenancy and lease compliance, living and household management, entitlement assistance and financial counseling to health and wellness. To qualify for home stabilization services, the EOHHS or the agency's authorized representative must determine that the beneficiary meets criteria applicable to the basis of coverage as follows:

    (01) Medicaid eligible families with children, including parent/caretakers and pregnant women. To qualify, a beneficiary must be: (a) considered homeless or at-risk of homelessness according to the HUD Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009; (b) in jeopardy of losing current housing due to non-payment of rent, unsafe living conditions or repeated episodes of conflict in the housing community as substantiated by a housing or health care provider; or (c) transitioning from an institution or residential treatment facility back into the community.

(02) Independent youth under age 19 (nineteen) or twenty-one (21) if eligible by virtue of SSI, and Chaffee eligible youth eligible under 1309.05.02(03). To qualify, a beneficiary must be: (a) considered homeless according to the criteria established in the U.S. McKinney-Vento Homeless Assistance Act of 1987; or (b) at-risk for or are transitioning from institutionally-based or residential treatment facilities, or congregate care back into the community.

1309.13 EPSDT Out-Of-Plan Services

For all Medicaid-eligible children and youth under age twenty-one (21), EPSDT requires coverage for all follow-up diagnostic and treatment services deemed medically necessary to ameliorate or correct defects and physical and mental illnesses and conditions discovered through screening, or at any occasion. Such medically necessary diagnosis and treatment services must be provided regardless of whether such services are covered by the State Medicaid Plan, as long as they are Medicaid-covered services as defined in the Title XIX or Title XXI of the Social Security Act or approved as part of the State's Section 1115 waiver.

The health plan must assure that all medically necessary, Medicaid-covered diagnosis and treatment services are provided, either directly or by referral. However, if the services are neither covered by the State Medicaid State Plan or the Section 1115 waiver nor included in the capitated benefit package, the health plan may bill the State fee-for-service. Such services include:

- Chiropractic
- Christian Science services
- Other services that are medically necessary (as determined and prior authorized by the state) to treat or ameliorate a condition that is discovered during an EPSDT screening.

1309.14 Communities of Care

The Medicaid agency has established a special service delivery system within both RIte Care and Rhody Health Partners managed care plans called the Communities of Care (CoC). The goal of the CoC is to improve access and promote member involvement in care in an effort to decrease non-emergent and avoidable Emergency Department (ED) utilization and associated costs. The target population or CoC are Medicaid members who utilize the ED four (4) or more times during the most recent twelve (12) month period. RIte Care members will be notified of the requirement to participate in CoC. Section 1314 of the MCAR sets forth the requirements of the CoC for MACC group eligible individuals and families, including those enrolled in RIte Care.

1309.15 Limits on Services

01. The following services are not covered under the RIte Care program:

- Experimental procedures, except as required by RI state law;
- Abortion services, except to preserve the life of the woman, or in cases of rape or incest;
- Private rooms in hospitals (unless medically necessary);
- Cosmetic surgery;
- Infertility treatment services; and
- Services of Institutions for Mental Diseases (IMD) for individuals age twenty-one (21) to sixty-five (65) except as available through a Medicaid managed care plan.

02. **Out-of-State Coverage**

Out-of-State Benefits — The Medicaid agency does not provide coverage for out-of-state services with two exceptions: Medicaid services provided in border communities are covered and emergency services are covered, within limits, at the discretion of the Medicaid agency.

1309.16 Scope of Provider Networks

The health plan must maintain provider networks in locations that are geographically accessible to the populations to be served, comprised of hospitals, physicians, mental health providers, substance abuse providers, pharmacies, transportation services, dentists, school based health centers, etc. in sufficient numbers to make available all services in a timely manner.

1309.17 Mainstreaming / Selective Contracting

The mainstreaming of Medicaid beneficiaries into the broader health delivery system is an important objective of the Medicaid program. The health plan must ensure that all of its network providers accept RIte Care members for treatment. The health plan also must accept responsibility for ensuring that network providers do not intentionally segregate RIte Care members in any way from other persons receiving services.

Health plans may develop selective contracting arrangements with certain providers for the purpose of cost containment, but must still adhere to the access standards as defined in the health plan contracts.

1309.18 Primary Care Providers (PCPs)

The health plan has written policies and procedures allowing every member to select a primary care provider (PCP). The PCP serves as the member's initial and most important point of interaction with

the health plan network. In addition to performing primary care services, the PCP coordinates referrals and specialty care. As such, PCP responsibilities include at a minimum:

- Serving as the member's primary care provider;
- Ensuring that members receive all recommended preventive and screening care appropriate for their age group and risk factors;
- Referring for specialty care and other medically necessary services both in- and out-of-plan;
- Maintaining a current medical record for the member; and
- Adhering to the EPSDT periodicity schedule for members under age twenty-one (21) or twenty-six (26), as appropriate.

In addition, the health plan retains responsibility for monitoring PCP actions to ensure they comply with health plan and Medicaid program policies.

1309.19 Service Accessibility Standards

The service accessibility standards which the health plan must meet are:

- Twenty-four-hour coverage;
- Travel time;
- Days to appointment for non-emergency services.

In addition, health plans must staff both a member services and a provider services function and a Provider Services function.

01. Twenty-Four Hour Coverage--The health plan must provide coverage, either directly or through its PCPs, to members on a twenty-four (24) hours per day, seven (7) days a week basis. The health plan must also have available written policy and procedures describing how members and providers can contact it to receive instruction or prior authorization for treatment of an emergent or urgent medical problem.

02. Travel Time --The health plan must make available to every member a PCP whose office is located within twenty (20) minutes driving time from the member's place of residence. Members may, at their discretion, select PCPs located farther from their homes.

03. Appointment for Non-Emergency Services --The health plan must make services available within twenty-four (24) hours for treatment of an urgent medical problem. The plan must make services available within thirty (30) days for treatment of a non-emergent, non-urgent medical problem. This thirty (30) day standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days. Non-emergent, non-

urgent mental health or substance abuse appointments for diagnosis and treatment must be made available within five (5) business days.

04. Member Services -- The health plan must staff a member services function operated at least during regular business hours and responsible for the following:

- Explaining the operation of the health plan and assisting members in the selection of a PCP;
- Assisting members to make appointments and obtain services;
- Arranging medically necessary transportation for members;
- Handling members' complaints; and
- Toll-free telephone number.

The health plan must maintain a toll-free Member Services telephone number. Although the full Member Services function is not required to operate after regular business hours, this or another toll-free telephone number must be staffed twenty-four (24) hours per day to provide prior authorization of services during evenings and weekends.

05. Provider Services - The health plan must staff a provider Services function operated at least during regular business hours and responsible for the following:

- Assisting providers with questions concerning member eligibility status;
- Assisting providers with plan prior authorization and referral procedures;

- Assisting providers with claims payment procedures;
- Handling provider complaints.

1309.20 Mandatory Participation in Managed Care

Participation in managed care is mandatory for the members of the MACC, non-MAGI and non-Medicaid funded coverage groups identified in section 1309.06, except as specified in MCAR section 1311.07. Medicaid members in these coverage groups with third-party medical coverage or insurance may be exempt from this mandate only as indicated in section 1309.06, at the discretion of the EOHHS.

1309.21 Exemptions from Managed Care – RIte Care only

Medicaid members are granted exemptions from mandatory enrollment in managed care in a narrow range of circumstances in accordance with the provisions set forth in section 1311.07. Among the unique RIte Care coverage groups identified in 1309.06, there is a special exemption for children and youth in, or aging out of, foster care who are up to age twenty-one (21). Children and young adults in this coverage group may be exempted from health plan enrollment at the discretion of the Department of Children, Youth and Families (DCYF) upon request to the Medicaid agency.

1309.22 Enrollment Procedures, Rights and Responsibilities

The enrollment process for MACC groups is set forth in MCAR section 1311.

1309.23 Information and Referral

REV: March 2014

For Further Information or to Obtain Assistance

01. Applications for affordable coverage are available online on the following websites:

- www.eohhs.ri.gov
- www.dhs.ri.gov
- www.HealthSourceRI.com

02. Applicants may also apply in person at one of the Department of Human Services offices or by U.S. Mail. Request an application by calling 1-855-609-3304 and TTY 1-888-657-3173.

03. For assistance finding a place to apply or for assistance completing the application, please call: 1-855-609-3304 or 1- 855-840-HSRI (4774).

1309.24 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

1309finaljuly2016
June 30, 2016